CENTER ON BUDGET AND POLICY PRIORITIES
820 First Street, NE, Suite 510, Washington, DC 20002
Tel: 202-408-1080 Fax: 202-408-1056 center@cbpp.org www.cbpp.org

May 19, 2004

Testimony of Robert Greenstein
Executive Director, Center on Budget and Policy Priorities

Hearing on "Health Savings Accounts and the New Medicare Law: The Face of Health Care's Future?"

before the Senate Special Committee on Aging

Mr. Chairman, Senator Breaux, and members of the Committee on Aging, I appreciate the invitation to testify today. I am Robert Greenstein, Executive Director of the Center on Budget and Policy Priorities, a non-profit policy institute that conducts research and analysis on fiscal policy and on programs and policies affecting low- and moderate-income families. The Center does not hold (and has never received) a grant or contract from any federal agency.

My written testimony focuses principally on three key issues related to Health Savings Accounts.

- The risk that widespread use of the recently enacted Health Savings Accounts (HSAs) will significantly weaken the comprehensive employer-based health insurance system through which the vast majority of Americans now obtain their health insurance. Because HSAs will be most attractive to healthy and more affluent workers, HSAs are likely over time to result in "adverse selection" — that is, in the separation of healthy and less-healthy workers into different insurance arrangements, with healthier workers shifting to HSAs and high-deductible policies and older and sicker workers seeking to remain in comprehensive insurance. This development may make the comprehensive health insurance coverage that employers now typically offer increasingly unaffordable over time for vulnerable older and sicker workers who need such coverage and seek to remain in it.

- The likelihood that the Administration's fiscal year 2005 budget proposal to provide a tax deduction for the premium costs of high-deductible health insurance purchased in the individual market in conjunction with HSAs would primarily benefit higher-income individuals who already are insured, and would *increase* the number of Americans without insurance because it would increase incentives for employers not to offer coverage. This proposal also would have a detrimental impact on both federal and state budgets.

- The danger that HSAs would serve as a damaging precedent for enactment of additional tax proposals that would aggravate an already bleak long-term federal fiscal outlook. HSAs breached the long-standing rule of the tax code that savings accounts may not feature *both* tax-deductible contributions *and* tax-free

withdrawals. Extending the type of "double-dip" tax benefits that HSAs offer into retirement accounts would make the long-term deficit picture markedly worse than it already is.

Brief Overview of the Health Savings Accounts Provisions in the Medicare Law

Health Savings Accounts were established as part of last year's Medicare drug legislation.[1] Under that law, any individual who enrolls in a high-deductible health insurance plan with a deductible of at least $1,000 for individuals and $2,000 for family coverage may establish a tax-favored savings account known as a Health Savings Account.[2] An individual with a HSA may take a tax deduction for contributions to the account equal to 100 percent of the health insurance deductible so long as the contributions do not exceed an annual limit, which is set at $2,600 for individuals and $5,150 for family coverage in tax year 2004.[3] Both employers and employees may make deductible contributions to HSAs in the same year; the aggregate contributions are subject to the contribution limit.

Funds held in these accounts may be placed in various investment vehicles such as stocks and bonds, with earnings accruing on a tax-free basis. Withdrawals from the account also are exempt from tax if they are used to pay for out-of-pocket medical costs such as deductibles, co-payments, and other uncovered medical expenses. Withdrawals for non-medical purposes are subject to income tax and a financial penalty, but no penalty applies to non-medical withdrawals made after reaching age 65.[4]

HSAs Pose Substantial "Adverse Selection" Risk to Comprehensive Employer-Based Health Insurance

Health Savings Accounts pose a significant risk of weakening the existing comprehensive employer-based health insurance market due to what economists and health analysts call "adverse selection," under which healthier, low-risk individual abandon one type of health insurance for another. When this occurs, the people who remain in the initial type of insurance constitute a group that becomes less healthy, on average, and hence more expensive to insure, which pushes up premiums for that type of coverage. The rise in premiums then induces still more of the healthier individuals to abandon that form of insurance. Over time, a so-called

[1] For an analysis of Health Savings Accounts generally, see Robert Greenstein and Edwin Park, "Health Savings Accounts in Final Medicare Conference Agreement Pose Threats Both to Long-Term Fiscal Policy and to the Employer-Based Health Insurance System," Center on Budget and Policy Priorities, revised December 1, 2003.

[2] In addition, the high-deductible health insurance plan must have an out-of-pocket limit of no more than $5,000 for individuals and $10,000 for family coverage. Certain preventive services such as annual physicals and routine screenings may be exempted from the deductible.

[3] Individuals age 55 or older may make additional contributions (in excess of the annual limit) of up to $500 in tax year 2004, rising to $1,000 by tax year 2009. Individuals age 65 or older are no longer eligible to make deductible contributions to HSAs.

[4] The financial penalty for a non-medical withdrawal prior to retirement age of 65 is equal to 10 percent. Unlike other retirement accounts, there are no mandatory withdrawals upon retirement.

"death spiral" can result, whereby healthy individuals abandon such coverage in mounting numbers, causing premiums to climb to levels that are unaffordable.[5] As discussed in greater detail below, due to the advent of HSAs, adverse selection is likely to occur as healthy individuals abandon comprehensive employer-based plans for high-deductible plans used in conjunction with HSAs.

Today, the employer-based health insurance system typically offers comprehensive health insurance coverage. Such coverage generally carries relatively modest deductibles and co-payment charges and covers a wide array of benefits. It may be provided through a variety of administrative structures including HMOs, Preferred Provider Organizations (PPOs), and Point-of-Service (POS) plans. (These are also the types of plans through which many members of Congress and their staffs obtain coverage, such as through the Blue-Cross-Blue-Shield Standard Option offered under the Federal Employee Health Benefits Program.)

Rapidly increasing health care costs and the current economic slump have encouraged some employers to increase the deductibles and co-payments that workers must shoulder and have somewhat reduced the scope of benefits.[6] Nevertheless, high-deductible plans are still far from the norm in employer-based coverage. For example, among PPO plans in 2003, the average in-network deductible was $275 per individual, well below the minimum $1,000 deductible for individuals required under HSAs.[7] As a result, according to the Joint Committee on Taxation, only a "very small number" of employers currently offer high-deductible plans meeting the statutory requirements of HSAs.[8]

With the advent of HSAs, however, many healthy workers are likely to find high-deductible plans considerably more attractive. Because of their excellent health, these workers would believe they will not require much health care and therefore will not need the greater financial protection that comprehensive coverage provides. Moreover, if they end up using little or no health care, healthy workers can accumulate funds in their HSAs on a tax-advantaged basis since earnings accrue tax-free in these accounts. In addition, as noted above, any funds that individuals deposit in HSAs are tax-deductible.

---

[5] An example of how adverse selection can occur in nature involves the Blue Cross-Blue Shield "high option" for federal employees, which had a somewhat lower deductible than the "standard option" and a slightly higher premium. Young and healthy employees ended up primarily choosing the standard option because they believed they could bear the risk of the higher deductible due to their health status and would rather pay a lower premium. Older and sicker employees, on the other hand, who preferred more comprehensive coverage because of their need for substantial health care services, participated in the high option. Over time, the premiums for the high option increased substantially due to the concentration of older and sicker workers in the high option. When last offered in 2001, the high option family coverage premium was $1,500 higher than the family coverage premium for the standard option. As a result, the high option was dropped from the Federal Employees Health Benefits Program. Leonard Burman and Linda Blumberg, "HSAs Won't Cure Medicare's Ills," Urban Institute, November 21, 2003.

[6] Sara R. Collins, Cathy Schoen, Michelle M. Doty and Alyssa L. Holmgren, "Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace," The Commonwealth Fund, March 2004.

[7] Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2003 Annual Survey," 2003.

[8] Letter from George K. Yin, Joint Committee on Taxation, to the Honorable Charles B. Rangel, November 21, 2003.

Healthy people who are affluent can find this particularly advantageous; higher-income workers can better afford the risk of high-deductible coverage if they do become sick, and they also secure the largest tax deductions for deposits into HSAs. That is because the value of a tax deduction rises with an individual's tax bracket. In addition, these workers' employers would be able to make deposits into their HSAs on their behalf. (Firms receive the full employer health-insurance deduction for such deposits.) Moreover, withdrawals from the accounts used for out-of-pocket medical costs are tax-free. Finally, unlike traditional Individual Retirement Accounts (IRAs), there are no income limits on who can participate in HSAs. As a result, these accounts can be quite lucrative as tax shelters for healthy and affluent individuals.

A recent survey of nearly 1,000 employers conducted by Mercer Human Resource Consulting appears to confirm the attractiveness of HSAs to healthy, higher-income workers. The survey found that a large majority of employers (61 percent) believed their *higher-paid* employees would be most likely to participate in HSAs. A plurality (44 percent) believed that their *healthiest* employees would be most likely to participate.[9] Similarly, evidence from a General Accounting Office survey of insurers that was conducted in conjunction with the Medical Savings Account demonstration project, which preceded HSAs and included fewer tax benefits, found that "insurers expect relatively better health status and lower service utilization by enrollees selecting high deductible plans."[10]

Older and sicker workers, on the other hand, would prefer to remain in the comprehensive coverage typically offered by employers today.[11] Early retirees would be one population that would tend to choose to remain in comprehensive coverage. A Commonwealth Fund study found that 26 percent of all adults ages 62-64 are in fair or poor health and require more health care services on average.[12] Older and sicker workers who have low incomes are particularly likely to prefer comprehensive plans, as they often would be unable to afford the greater out-of-pocket costs required under high-deductible plans. Moreover, low-income individuals derive little or no benefit from the tax benefits of HSAs, and they generally lack the income or resources to make substantial contributions to HSAs.

---

[9] Mercer Human Resource Consulting, "US Employers See a Role for New Health Savings Accounts in their Benefit Programs," April 26, 2004.

[10] General Accounting Office, *Medical Savings Accounts: Results from Surveys of Insurers*, December 31, 1998, GAO/HEHS-99-34, Appendix.

[11] Some proponents of HSAs dispute this notion. They argue that sicker individuals would prefer high-deductible plans because it provides protection against catastrophic costs once the deductible is exceeded. This, however, is quite unlikely to be the case. There is no requirement that high-deductible plans related to HSAs provide 100 percent coverage for health care costs in excess of the deductible. The only requirement is that such plans have an overall out-of-pocket limit of no more than $5,000 for individuals and $10,000 for family coverage. Such limits are well above the out-of-pocket limits currently found in traditional comprehensive employer-based coverage. Not only do traditional comprehensive employer-based plans generally require significantly lower deductibles, but among all PPO plans in 2002 (the last year for which such data are available), 79 percent set a maximum out-of-pocket limit of $3,000 or less. Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2002 Annual Survey," 2002.

[12] John Sheils and Ying-Jun Chen, "Medicare Buy-In Options: Estimating Coverage and Costs," The Commonwealth Fund, February 2001.

Would Widespread Use of HSAs Reduce Overall Health Care Costs?

Proponents of HSAs argue that high-deductible policies would discourage unnecessary utilization of health care services by requiring individuals to bear a greater portion of the costs of their care. As a result, supporters argue HSAs would produce substantial reductions in overall health care spending in the United States over time.

It is unlikely, however, that HSAs would provide significant cost containment. According to recent research, 10 percent of the population accounts for 69 percent of total health care spending, and as Henry Aaron, a Senior Fellow at the Brookings Institution and a leading expert in the areas of health care and tax policy, explains in a recent *Tax Notes* article: "…most medical spending occurs during high-cost episodes in which the total cost of care charged to patients greatly exceeds the limits of any plausible high-deductible plan....Once patients enter the stop-loss range of their insurance, they would, by definition, be as free of financial discipline to attend to health care costs as they are under low-deductible insurance. The direct effects of high-deductible insurance on health care costs are therefore likely to be small." Similarly, Linda Blumberg, a Senior Research Associate at the Urban Institute, has concluded: "Because the majority of spending is attributable to the small share of individuals with very large medical expenses, increasing deductibles even to $1,000 or $2,000 from currently typical levels will not decrease premiums dollar for dollar. The vast majority of medical spending still will occur above even these higher deductibles."

It also should be noted that research indicates that increased cost-sharing requirements are a blunt instrument with which to try to control costs. Among low-income individuals, higher cost-sharing charges can discourage utilization of *both* necessary and unnecessary services. If a medical condition or illness goes untreated because individuals are unable to pay for appropriate care out-of-pocket, this can eventually lead to greater use of more expensive services like hospitalization. For some individuals, the high-deductible insurance policies required under HSAs thus might actually result in increases in health care costs over time.

---

* Karen Davis, Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions, January 28, 2004 citing A.C. Monheit, "Persistence in Health Expenditures in the Short-Run: Prevalence and Consequences," *Medical Care* 41, supplement 7:1153-1164, 2003; Henry Aaron, "HSAs — The 'Sleeper' in the Drug Bill," *Tax Notes*, February 23, 2004; Linda J. Blumberg, Testimony before the Subcommittee on Workforce, Empowerment and Government Programs, U.S. House Committee on Small Business, March 18, 2004; and see also Jon R. Gabel, Heidi Whitmore, Thomas Rice and Anthony T. LoSasso, "Employers' Contradictory Views about Consumer-Driven Health Care: Results from a National Survey," Health Affairs (Web Exclusive), April 21, 2004.

With healthy, affluent workers moving to high-deductible plans in conjunction with HSAs while older and sicker workers remain in comprehensive coverage, premiums for comprehensive plans would necessarily rise. Research conducted in the mid-1990s on the likely effects of Medical Savings Accounts by RAND, the Urban Institute, and the American Academy of Actuaries concluded that the risks of adverse selection were quite high and that premiums for comprehensive insurance could more than double if MSA use becomes widespread.[13]

---

[13] Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" Journal of the American Medical Association, June 5, 1996, p. 1666-71; Len M. Nichols, et. al., "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," The Urban Institute, April 1996; and American Academy of Actuaries, "Medical Savings Accounts: Cost Implications and Design Issues," May 1995.

In the past, some have downplayed the risks of adverse selection on the grounds that HSAs are unlikely to proliferate in the employer-based health insurance market. It is increasingly clear that such a judgment is mistaken. To provide benefits that are attractive to their managers, firms generally must provide low-cost, comprehensive coverage to all of their workers. With HSAs, however, employers can provide less costly, less generous high-deductible plans tied to HSAs without worrying as much that such plans might encourage executives to seek jobs elsewhere that offer better health benefits. High-income managers and executives could use their HSAs as tax shelters by making substantial contributions to the HSAs on a tax-deductible basis. Since these individuals would have the ability to accumulate significant amounts in their HSAs — and the value of the HSA tax break is greatest for those in the top tax brackets — these tax benefits could more than make up for the increases in deductibles and other reductions in covered benefits that the executives could face under the high-deductible plans their employers might substitute for more comprehensive coverage. With health insurance premium costs rising annually at double-digit rates in recent years, this could make HSAs particularly attractive to employers.

For rank-and-file lower-income workers, however — and especially for older, less healthy workers — such a change would generally be harmful. Those workers would lose the comprehensive low-deductible insurance that they need and receive in its place a tax break of little value to them.[14]

In providing a cost estimate to accompany the Medicare prescription drug bill, the Joint Committee on Taxation assumed that HSA would expand significantly, starting at one million participants in tax year 2004 and rising to three million by 2013. (By comparison, in tax year 2001, the most recent year for which IRS data are available, fewer than 80,000 people participated in the Medical Savings Account demonstration project).

But most analysts now believe the JCT estimate dramatically understates likely HSA use, given the widespread attention that HSAs are receiving and the intention of various insurance and financial investment companies to offer HSAs and high-deductible policies and market them heavily. The Administration now estimates that the HSA provisions of the new Medicare law will cost $16 billion over ten years, two-and-a-half times the $6.4 billion that Congress assumed when the law was enacted. In addition, the employer survey discussed above found that nearly three-quarters of employers (73 percent) are likely or somewhat likely to offer Health Savings Accounts by 2006. A smaller employer survey conducted by Hewitt Associates found that 61 percent of employers are likely to offer HSAs in the near future.[15]

---

[14] Some proponents of HSAs may argue that employers will hold workers harmless — that the increase in the deductible will be offset by an employer contribution to the HSA equal to the difference between the current deductible required under a comprehensive plan and the one required under the high-deductible health insurance plan provided in conjunction with the HSA. To the degree that employers are looking at HSAs as a lower-cost health insurance alternative, however, this does not appear likely. In the Mercer employer survey, 77 percent of employers expected their HSA contribution amounts to be lower than the deductible amount in the high-deductible plan that they would offer in connection with HSAs, and a plurality of employers (39 percent) expected they would not make any contribution at all to workers' HSAs. Mercer Human Resource Consulting, *op cit*.

[15] Hewitt Associates, "Addition of HSAs Will Require Substantial Health Plan Design Changes," March 31, 2004.

If HSA use becomes widespread, as is likely, and premiums for the comprehensive coverage typically offered by employers today rise substantially (with some employers dropping comprehensive coverage entirely), many older and sicker workers, including early retirees, would suffer adverse consequences. Such individuals would either have to switch to a high-deductible plan or become uninsured.

Coverage through high-deductible plans would leave many such individuals underinsured; such plans are likely to provide inadequate coverage for these workers. A Commonwealth Fund study reported that older individuals ages 50-64 who have purchased high-deductible policies in the individual market similar to the plans required under HSAs are twice as likely as comparable individuals with comprehensive employer-based coverage to fail to see a doctor when a medical problem develops or to skip medical tests or follow-up treatment.[16] Another Commonwealth analysis determined that so-called "bare-bone" health plans — which may be comparable to some of the high-deductible plans provided with HSAs — can leave some lower-wage individuals and families with catastrophic costs well in excess of their annual incomes.[17]

A study conducted by the Center for Studying Health System Change estimated that high-deductible, less comprehensive plans would expose many individuals to substantial out-of-pocket costs; nearly a third of individuals in poor health enrolled in hypothetical plans with high deductibles of $1,000 were projected to incur out-of-pocket costs in excess of 10 percent of their annual incomes. The study also estimated that more than half of such individuals would incur out-of-pocket costs of this magnitude if they were enrolled in hypothetical plans with deductibles of $2,500.[18]

As Linda Blumberg of the Urban Institute recently warned, "the practical effect [of HSAs]…is that the most vulnerable populations (the sick and low-income) are left bearing a greater burden of their health expenses."[19] Such individuals will either have to spend more out-of-pocket or go without essential health care services they may need. A study from the Employee Benefit Research Institute concludes that the loss of comprehensive coverage generally would leave many people who need significant amounts of health care, such as individuals with chronic conditions, little recourse but to become underinsured or uninsured."[20]

---

[16] Elisabeth Simantov, Cathy Schoen and Stephanie Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," Health Affairs, July/August 2001.

[17] Shery Glied, Cathi Callahan, James Mays and Jennifer Edwards, "Bare-Bones Health Plans: Are They Worth the Money?," The Commonwealth Fund, May 2002.

[18] Sally Trude, "Patient Cost-Sharing: How Much Is Too Much?," Center for Studying Health System Change, December 2003.

[19] Linda J. Blumberg, Testimony before the Subcommittee on Workforce, Empowerment and Government Programs, U.S. House Committee on Small Business, March 18, 2004.

[20] Laura Tollen and Robert Crane, "A Temporary Fix? Implications of the Move Away from Comprehensive Health Benefits," Employee Benefit Research Institute, April 2002.

Proposed Deduction for the Premium Cost of High-Deductible Health Insurance Purchased in the Individual Market Would Worsen Problem of Uninsured

At a cost of $25 billion over ten years, the Administration's fiscal year 2005 budget proposes to further expand enrollment in Health Savings Accounts by allowing HSA participants to claim a tax deduction for the premium costs of high-deductible health insurance policies they purchase in the individual health insurance market.[21] (The deduction would not be available to HSA participants who obtain high-deductible coverage through their employer.) The deduction would be available without regard to whether an individual itemizes deductions.

M.I.T. economist Jonathan Gruber, one of the nation's leading health economists, has analyzed the proposal, using his highly regarded health insurance model. Gruber's analysis finds that because of the adverse effects it would have on employer-based coverage, this deduction would likely cause the ranks of the uninsured to *increase* by 350,000.

The value of a tax deduction rises with an individual's tax bracket. The proposed deduction consequently would be of greatest benefit to high-income taxpayers, who would receive the largest tax benefits from the deduction because they are in the highest tax brackets. The vast bulk of people in the higher tax brackets who would use the deduction, however, will have health insurance *regardless* of whether the deduction is established.

At the other end of the income spectrum, workers who do not earn enough to owe income tax would receive no benefit whatsoever from the deduction. In addition, for moderate- and middle-income taxpayers in the 10 percent or 15 percent tax brackets, the deduction would reduce the cost of health insurance policies by only 10 percent or 15 percent, too little in most cases to make health insurance affordable. This is significant because about three-quarters of all U.S. households — and something like 90 percent of the uninsured — are either in the 10 percent or 15 percent tax bracket or earn too little to owe income tax.[22] As a result, the deduction would have only small effects in helping the uninsured purchase high-deductible health insurance policies in the individual market.

The deduction thus poses a problem: it would not do much to help people who cannot afford insurance to secure it. Yet the availability of HSAs and the deduction would encourage some employers to drop employer-based coverage (or not to offer it in the first place), since their workers could now receive tax preferences if they use HSAs and purchase high-deductible policies on their own. In research conducted for the Kaiser Family Foundation, Professor Gruber examined the coverage effects of the proposed deduction. He found that the number of workers who would lose coverage because of actions by their employers to drop coverage (or to decrease

[21] Currently, funds held in HSAs may not be generally used to pay the premium costs of health insurance. There are limited exceptions to the rule that tax-free withdrawals from HSAs may not be used to pay premiums for health insurance. Tax-free withdrawals from HSAs may be used to pay for health insurance premiums under COBRA or while an individual is unemployed, for long-term care insurance premiums, or for premiums for private supplemental coverage under Medicare.

[22] In an analysis issued in 1998, the General Accounting Office found that more than 90 percent of the uninsured had no tax liability or were in the 15 percent tax bracket. General Accounting Office, Letter to the Honorable Daniel Patrick Moynihan, June 10, 1998. The 10 percent tax bracket, which was carved out of the 15 percent bracket by the 2001 tax legislation, did not yet exist.

employer contributions toward health insurance premiums) would likely *exceed* the number of uninsured individuals who would gain coverage as a result of the deduction.

Specifically, Professor Gruber, who is highly regarded in the economics profession for the rigor of his work on health care and other matters, projects that nearly eight million people would use the proposed tax deduction.[23] But he also projects that only about 1.1 million of these participants — or 13 percent of them — would previously have been uninsured. Nearly 87 percent of those who would use the deduction would already have health insurance (of whom the overwhelming majority would have coverage they purchased through the individual market) and would essentially be obtaining a tax break for insurance they already can afford (see Table 1).

Table 1
Projected Effects of Fiscal Year 2005 Administration HSA Deduction Proposal in Reducing the Number of Uninsured

Projected number of total participants in the tax deduction	7.98 million
Number of participants who would previously have had health insurance coverage	6.91 million (86.6%)
Number who would previously have been uninsured and would gain coverage	1.07 million (13.4%)
Number who would previously have had employer-based coverage but would become uninsured as their employers dropped coverage or reduced their premium contributions.	-1.41 million
Net effect on number of individuals with health insurance coverage	-350,000

* Analysis by Professor Jonathan Gruber, March 12, 2004. Numbers may not add due to rounding.

Gruber also finds that the deduction would prompt some employers to drop existing employer-sponsored coverage or, in the case of new employers, to elect not to offer it. The combination of HSAs and the availability of the new tax deduction to workers who obtain health insurance in the individual market — rather than through their employer — would almost certainly be regarded by some employers as lessening the need for them to offer coverage. Professor Gruber estimates that employers currently covering 2.1 million workers would drop coverage. He estimates that 1.2 million of these workers — a little more than half of them — would become uninsured.

Some employers would be expected to retain coverage but to scale back their contributions to the premium costs of coverage, on the grounds that the new deduction lessens the need for as significant an employer contribution. Gruber finds that a modest number of workers whose employers would reduce employer contributions — 190,000 such workers — would drop out of employer-based coverage and become uninsured. This brings to 1.4 million

[23] Communication with Professor Jonathan Gruber, March 12, 2004. See also Kaiser Family Foundation, "Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals," March 2004. The analysis that Professor Gruber conducted for the Kaiser Family Foundation report determined the simultaneous coverage effects of both the deduction and the Administration's proposal to provide a refundable tax credit for the purchase of health insurance in the individual market. The analysis cited here and communicated to CBPP shows the effects of the deduction separately.

the total number of people who would lose coverage and become uninsured as a consequence of employer actions taken in response to the establishment of deduction.

With about 1.1 million uninsured people gaining coverage as a result of the deduction and about 1.4 million losing coverage, Gruber's analysis finds that the likely net effect of the deduction would be to increase the number of uninsured individuals by approximately 350,000 (see Table 1).

The deduction also would affect the budget. Unless its costs were fully offset, the proposal would increase federal deficits. As noted, the Administration now expects the HSA provisions enacted as part of the Medicare prescription drug legislation to cost two-and-a-half times as much as the Joint Committee on Taxation estimated when the Medicare legislation was enacted. Many experts share the Administration's view that the Joint Tax Committee's estimate of the cost of the HSA provisions, upon which Congress relied when enacting the Medicare legislation, is too low. HSA use now is expected to be significantly more widespread than the Joint Committee on Taxation assumed when it developed the cost estimate for the HSA part of the Medicare bill.

The proposed deduction would cause use of HSAs to become still more widespread, further intensifying the risks of adverse selection, because the deduction would substantially enhance the already-generous tax benefits that HSAs offer, especially to individuals in the higher tax brackets. This is part of the reason that the proposed deduction carries a $25-billion price tag.

The Administration projects that the combined cost of the HSA provisions in the Medicare drug legislation and the new deduction would be nearly $41 billion over ten years. To put this figure in perspective, when Congress passed the Medicare bill, it thought the cost of the bill's HSA provisions would be $6.4 billion over ten years, based on the Joint Tax Committee estimate — less than one-sixth as much.

The proposed deduction also would place some strain on state budgets. State income tax codes generally conform to the definition of taxable income in the federal income tax code. Many states consequently would experience revenue losses if the proposed deduction became law.

HSAs Also Constitute Dangerous Precedent for Long-Term Fiscal Policy

Under the tax code, a basic principle governs: If contributions to a savings or retirement account are tax deductible and earnings on the account compound tax-free, then withdrawals from the account are taxed as ordinary income. This is how 401(k)s, traditional IRAs, and similar accounts long have worked. (There are several types of accounts from which withdrawals are tax-free, but contributions to those accounts are *not* tax deductible.)

Under Health Savings Accounts, this fundamental principle is abrogated. Not only are deposits to HSAs tax deductible, with earnings then compounding on a tax-free basis, but *withdrawals also are tax free* so long as they are used for medical costs. Allowing an account to feature *both* tax-deductible contributions *and* tax-free withdrawals is unprecedented. (Note:

This was a feature of Medical Savings Accounts which preceded HSAs, but MSAs operated only as a demonstration project on a very limited basis and were not available to most people. Unlike MSAs, HSAs are universally available and provide more extensive benefits as a tax shelter.)

The Congressional Budget Office projects that the federal government will collect several trillion dollars in revenue over the course of future decades as tens of millions of Americans retire and withdraw funds from 401(k)s and IRAs. These anticipated revenues are reflected in the long-term budget baseline. Even with these revenues, the long-term fiscal picture is bleak; budget deficits are expected to rise eventually to levels dangerous to the economy. Stern warnings about the fiscal dangers that lie ahead have been voiced recently by the International Monetary Fund, the Comptroller General of the United States (the head of the General Accounting Office), the Chairman of the Federal Reserve, the investment house Goldman Sachs, and such luminaries as former Treasury Secretary Robert Rubin, former Senator Warren Rudman, and former Congressional Budget Office director Robert Reischauer.

For example, the *New York Times* reported that an IMF report issued in January "sounded a loud alarm about the shaky fiscal foundation of the United States…warning that large budget deficits pose 'significant risks' not just for the United States but for the rest of the world."[24] In strong language usually reserved for developing countries struggling with international debt obligations, the IMF report disapprovingly noted that the "United States is on course to increase its next external liabilities to around 40 percent of GDP within the next few years — an unprecedented level of external debt for a large industrial country."[25]

If the precedent that HSAs set is pursued — and policymakers begin allowing some of the funds deposited in retirement accounts into which contributions were made on a tax-deductible basis to be withdrawn tax free, so long as they are used for health care or some other designated purpose — an already grim long-term fiscal outlook will become considerably worse**.** In a recent scholarly assessment of the nation's long-term fiscal problems, Alan Auerbach of the University of California at Berkeley, one of the nation's leading public finance experts, and Brookings economists William Gale and Peter Orszag warn that "…proposals to reduce the taxation of withdrawals from retirement accounts could significantly and adversely affect an already bleak fiscal outlook."[26]

Indeed, financial services industry lobbyists have already begun promoting the idea of letting workers designate a portion of their 401(k)s and IRAs as "Retirement Medical Benefit Accounts" (or RMBAs), from which funds deposited on a deductible basis could be withdrawn in retirement on a tax-free basis for out-of-pocket medical costs.[27] Such a step would result in

---

[24] Elizabeth Becker and Edmund Andrews, "I.M.F. Warns that U.S. Debt is Threatening Global Stability," *The New York Times*, January 8, 2004.

[25] International Monetary Fund, "U.S. Fiscal Policies and Priorities for Long-Run Sustainability," IMF Occasional Paper 227, January 7, 2004.

[26] Alan J. Auerbach, William G. Gale, and Peter R. Orszag, "Reassessing the Fiscal Gap: The Role of Tax-Deferred Savings," *Tax Notes*, July 28, 2003.

[27] For an analysis of the RMBA proposal, see Edwin Park and Robert Greenstein, "New Retirement Medical Account Proposal Would Create Lucrative Tax Shelter and Swell Deficits, But Do Little to Help Low- and Moderate-Income Seniors with Health Care Costs."

large revenue losses over time, materially worsening the nation's long-term fiscal position. Such a proposal also could open the floodgates for proposals to allow steadily increasing shares of 401(k) and IRA assets to be set aside for favored purposes and then withdrawn tax-free for those purposes in retirement. If that occurs, the long-term fiscal consequences could be profound. As with the proposed premium deduction for HSAs, RMBAs also would place a strain on state budgets.

Over time, the RMBA proposal also could result in adverse effects on non-affluent Medicare beneficiaries. The large long-term revenue losses that the proposal would engender could intensify budgetary pressures to cut Medicare and other programs down the road.

Furthermore, the existence of RMBAs could facilitate the emergence of proposals to increase Medicare premiums, deductibles, and other cost-sharing charges quite substantially over time. The RMBA proposal may be marketed now partly as a way to help future Medicare beneficiaries pay for Medicare premiums, deductibles, and cost-sharing. But in the future, when the long-term effects of the tax cuts in shrinking the nation's revenue base collide with the mounting costs for retirement and health care programs for the elderly, RMBAs could be used to advance controversial proposals to reduce Medicare services markedly or increase substantially the charges that Medicare beneficiaries must pay. The argument would be that Medicare beneficiaries could absorb increased charges and decreased coverage in Medicare because they could draw funds tax free from RMBAs to help defray such costs.

That may be true for high-income beneficiaries. But RMBAs are likely to be of little help to most low- and moderate-income people; they would primarily be a windfall for the more well-off. Since high-income households are in the highest tax brackets, they would secure the largest tax deductions for contributions to these accounts, and they also would garner the largest tax benefits from being able to withdraw funds from the accounts on a tax-free basis. In addition, high-income individuals are the people who could most afford to make large deposits into such accounts.

But data on participation in, and contributions to, IRA and 401(k) accounts show the majority of low- or moderate-income households do not even have such accounts. A combination of RMBAs and increases in Medicare beneficiary charges would likely have a net positive effect on the pocketbooks of high-income Medicare beneficiaries but a decidedly negative effect on senior citizens of modest means.

Conclusion

Use of Health Savings Accounts is likely to become more widespread over time. Such a trend is likely to create a troubling system of winners and losers in the U.S. health care system. Individuals who are healthy and affluent would gain from the tax benefits that HSAs offer. Older and sicker workers, especially those with low incomes, would generally be made worse off by having to shoulder a greater percentage of the costs of their care then they do now. As a result, some of them likely will lose access to some important medical services they need.

Enactment of the proposed HSA-related tax deduction would not only further increase participation in HSAs, intensifying the risks of adverse selection, but would also be likely to increase the ranks of the uninsured by creating financial incentives for employers no longer to offer coverage to their workers. Finally, enactment of tax policies that build on the HSA precedent of providing both tax-free contributions and tax-free withdrawals would worsen an already exceedingly bleak long-term federal fiscal outlook.